WHAT IS CLAIMED IS:

1. A rules-based benefit claim pre-adjudication method for maximizing service provider/medical facility administrative and clinical efficiencies comprising the steps of:

generating a patient benefits plan at the service provider/medical facility location;

defining the treatments and conditions of a patient claim for benefits;

analyzing the patient claim for benefits to generate a preliminary EOB and to determine medical necessity protocols as defined by patient benefit plan and PIC standards;

verifying compliance of treatments and conditions in the patient claim for benefits with applicable standards;

predetermining monetary allowance for medical services rendered based upon applicable payment schedules; and

submitting the pre-adjudicated claim to a designated payer in accordance with the patient benefit plan.

2. The rules-based benefit claim pre-adjudication method as defined in claim 1, further including the step of mapping data elements originating in the medical community to EOB data elements originating in the PIC universe to complete a patient benefits plan to determine the internal protocols of the PIC.

3. The rules-based benefit claim pre-adjudication method as defined in claim 2, further including the step of applying coding initiatives defining treatments interactively or batch with the RBS applicable standards to assure the likelihood of acceptance of a claim for payment.

4. The rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying medical necessity treatments and diagnoses

linkages coding appropriateness interactively or batch with the RBS applicable standard to assure the likelihood of acceptance of a claim for payment.

5. The rules-based benefit claim pre-adjudication method as defined in claim 4, further including the steps of:

analyzing a PIC-generated EOB for the benefit claim submitted;

identifying treatments and conditions paid at a different rate than that determined in the pre-adjudicated claim submitted;

identifying exception treatments and conditions qualifying for reimbursements; and

updating the patient benefit plan and rules-based pre-adjudication applicable standards to incorporate the analyzed PIC-generated EOB information whereby the rules-based pre-adjudication system is self-regulating.

6. The rules-based benefit claim pre-adjudication method as defined in claim 5, further including the step of analyzing historical PIC-generated EOBs for other patients in accordance with the updated patient benefits plan to identify additional qualifying treatments and conditions not previously claimed and submitted or previously claimed and rejected.

7. The rules-based benefit claim pre-adjudication method as defined in claim 5, further including the step of analyzing historical PIC-generated EOBs for other patients by ZIP code to identify treatments and conditions qualifying for reimbursement for some patients and not other patients within a given patient's benefits plan, and submitting a benefit claim for the unpaid identified treatments and conditions qualifying for reimbursement.

8. The rules-based benefit claim pre-adjudication method as defined in claim 5, further including the steps of:

analyzing historical PIC-generated EOBs for other patients by different ZIP codes to identify treatments and conditions qualifying for reimbursement for some patients and not other patients within a given patient's benefits plan;

advising a service provider/medical facility having a potential qualifying benefit claim for a previous unclaimed or rejected claim for a patient in the given patient's benefits plan; and

submitting the potential qualifying benefit claim for reimbursement.

9. The rules-based benefit claim pre-adjudication method as defined in claim 3, including the step of applying Medicare correct-coding initiative to the rules-based adjudication system.

10. The rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying proprietary benefit plan specific coding initiatives to the rules-based pre-adjudication system.

11. The rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying insurance company or benefit plan administrator's utilization standards to the rules-based pre-adjudication system.

12. The rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of validating benefits plan specific medical necessity coding linkages and rules to the rules-based pre-adjudication system.

13. The rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of applying terms and conditions of agreements between a service provider/medical facility and a managed care organization/insurance company to the rules-based pre-adjudication system.

14. The rules-based benefit claim pre-adjudication method as defined in claim 3, further including the step of re-pricing services rendered at a service provider/medical facility according to a managed care or non-managed care fee schedule.

15. The rules-based benefit claim pre-adjudication method as defined in claim 1, wherein the step of defining treatments and conditions further includes the steps of:

validating patient's information data content;

applying a proprietary claim editor using a relational database comprising coding tables to identify appropriate procedural and diagnostic codes and applicable linkages.

16. A rules-based system for pre-adjudication of a benefits claim, said system comprising:

a source of claim data capable of identifying patient demographics and benefits plan coverage;

means at a benefit provider site for accessing the claim data source to capture historical claim data and update patient's current information;

at least one set of pre-adjudication rules corresponding to the type of patient benefits plan coverage; and

audit processing means for validating in accordance with said at least one set of pre-adjudication rules treatments and conditions coding and identifying applicable related treatments and conditions codes corresponding to the patient's diagnosis and prior treatment history to generate a suggested treatment plan to the provider whereby treatments are matched with conditions and applicable excluded treatments codes are identified.

17. The rules-based system for pre-adjudication of a benefits claim as defined in claim 16, wherein said audit processing means further includes means for comparing, in accordance with said at least one set of pre-adjudication rules, historical PIC-generated EOB results with submitted treatments codes and matched treatments and conditions

codes and applicable excluded treatments codes to generate a suggested treatment plan at a more successful payment rate.

18. A method for pre-adjudication of benefits claim submission to a payer, said method comprising the steps of:

preparing benefits claim data including identifying a patient, an insured covering the patient, benefit policy and plan codes applicable to the patient and treatments codes corresponding to conditions performed on the patient by a provider;

analyzing the benefits claim data in accordance with at least one set of predefined rules for conformity of claim data elements to a set of pre-established criteria;

validating the treatments and conditions codes specified in the benefits claim data;

verifying that the correct coding initiatives comply with the benefits policy and plan code identified in the benefits claim data preparation step;

valuating each benefit associated with the specified treatments and conditions codes;

reviewing each identified benefit value in accordance with the Policy Issuing Company agreement terms and conditions and generating a corresponding acceptance message or correction request message;

forwarding the benefits claim to the Policy Issuing Company identified in the benefit claim data preparation step;

presenting the benefits claim to the Policy Issuing Company for generation of an EOB in response to the benefit claim complying with the claim request requirements or in response to provider instructions;

reviewing the PIC-generated EOB to capture remark codes to determine priority of action and generating corresponding trigger messages in response thereto and

identifying rule deviations corresponding to benefits claim payments made and non-payment of qualifying benefits claim;

updating said at least one set of predefined rules to incorporate changes resulting from the PIC-generated EOB review step; and

generating messages reflecting priority of benefits claim coding to maximize provider reimbursement.